PREVENTION HEALTH AND HEALTH SERVICES BLOCK GRANT
Health Incentive Program
Grant Cash Transactions Report

LOCAL JURISDICTION_____ FFY 2005

Please indicate which quarter is being reported:

_____1st Qtr. (10/1 - 12/31/04)* _____2nd Qtr. (1/1 - 3/31/05)*

_____3rd Qtr. (4/1 - 6/30/05)* _____4th Qtr. (7/1 - 9/30/05)*

_____* FINAL REPORT: Program Plan health objectives have been met for the year.

1. State agency, office, and person to which report is submitted:
   California Department of Health Services, County Health Services Unit, MS 5202
   P. O. Box 997413, Sacramento, CA 95899-7413
   Attention: Susan R. Keim, (916) 552-8050 (E-mail: skeim@dhs.ca.gov)

2. **Federal Catalog Identification number - 93.991**

3. Recipient: _____

   Address:_____

   City:_____ Zip Code:_____

4. Employer's Identification Number (if applicable): _____

5. Period covered by report: _____

6. Cash on hand - beginning of period $_____

7. Receipts:
   A. Reimbursements $_____
   B. Advances $_____

8. Total Receipts (sum of 7A and B) $_____

9. Total cash available (sum of lines 6 and 8) $_____

10. Gross disbursements $_____

LOCAL JURISDICTION_____

11. Grant share of income $_____

12. Net disbursements (line 10 minus line 11) $_____

13. Adjustments of prior periods $_____

14. Cash on hand - end of period $_____

15. The amount shown on line 14, above, represents cash requirements for the ensuing _____days.

16. Interest income during the period $_____

17. Advances during the period

    Sub-grantee $_____

    Sub-contractor $_____

18. Name and title of person filling out this report:

19. Phone number of person filling out this report:

    Telephone No. (_____)_____ Extension_____

    FAX No. (_____)_____

****

I certify, to the best of my knowledge and belief, that this report is correct and complete and that all disbursements have been made in accordance with the Certification document.

Signature _____ Date _____

Title _____ Telephone No. (____)_____

E-mail: _____

****